ME - 2

Answers to Technical and Business Proposal Questions

American Stop Smoking Intervention Study for Cancer Prevention (ASSIST)
RFP #NCI-CN-95165-38

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State of Maine

Technical Questions

Factor 1: Management Approach

Question 1. **Please provide further information about the respective roles and responsibilities of staff and coalitions, and how the proposed structure relates to implementation of ASSIST primarily in 2 sites and secondarily across the state.**

Details of staff roles and responsibilities and coalition roles and responsibilities are described in Section V, Management Plan and Section VI, Maine ASSIST Coalition in the Technical Proposal. Please find below a detailed referencing of the items in the technical proposal as well as clarification regarding the relative roles of various staff members and the coalition, its various subcommittees and resource groups.

A detailed coalition structure was proposed in Section VI of the Technical Proposal. In order to understand the respective roles and responsibilities of staff and coalitions, a description of the Maine ASSIST coalition is presented first, followed by a description of staff roles and responsibilities.

A diagram of the Maine ASSIST Coalition, presented on page 146 of the Technical Proposal, is provided below. The Maine Project ASSIST proposal recognizes the importance of coalition functioning and maintenance (as detailed in numerous items in the management plan and summarized below as well) and the critical issue of coalition structure. The Technical Proposal stated, on page 144-145:

> due to the magnitude of the public health problem of tobacco use, the great significance of social and cultural aspects in its prevention and control and the tremendous resources necessary for its control, a coalition approach to tobacco control is essential. As previously stated, Maine has a strong history of using coalitions to promote action for health. Thus, the participants in the Maine ASSIST Coalition are experienced in functioning in this manner.

This section describes the Maine ASSIST Coalition membership and structure including the Advisory Committee (and its relationship to the Executive Committee), the subcommittees and technical resource groups. The Maine ASSIST Coalition structure is designed to reach the specified target populations through the intervention channels necessary for a comprehensive smoking prevention and control program.

In order to accomplish its goals, a coalition must (a) have a structure that enables efficient and effective action-oriented functions and (b) have established, agreed upon procedures and guidelines for functioning. Coalition functional issues are described in SECTION V.

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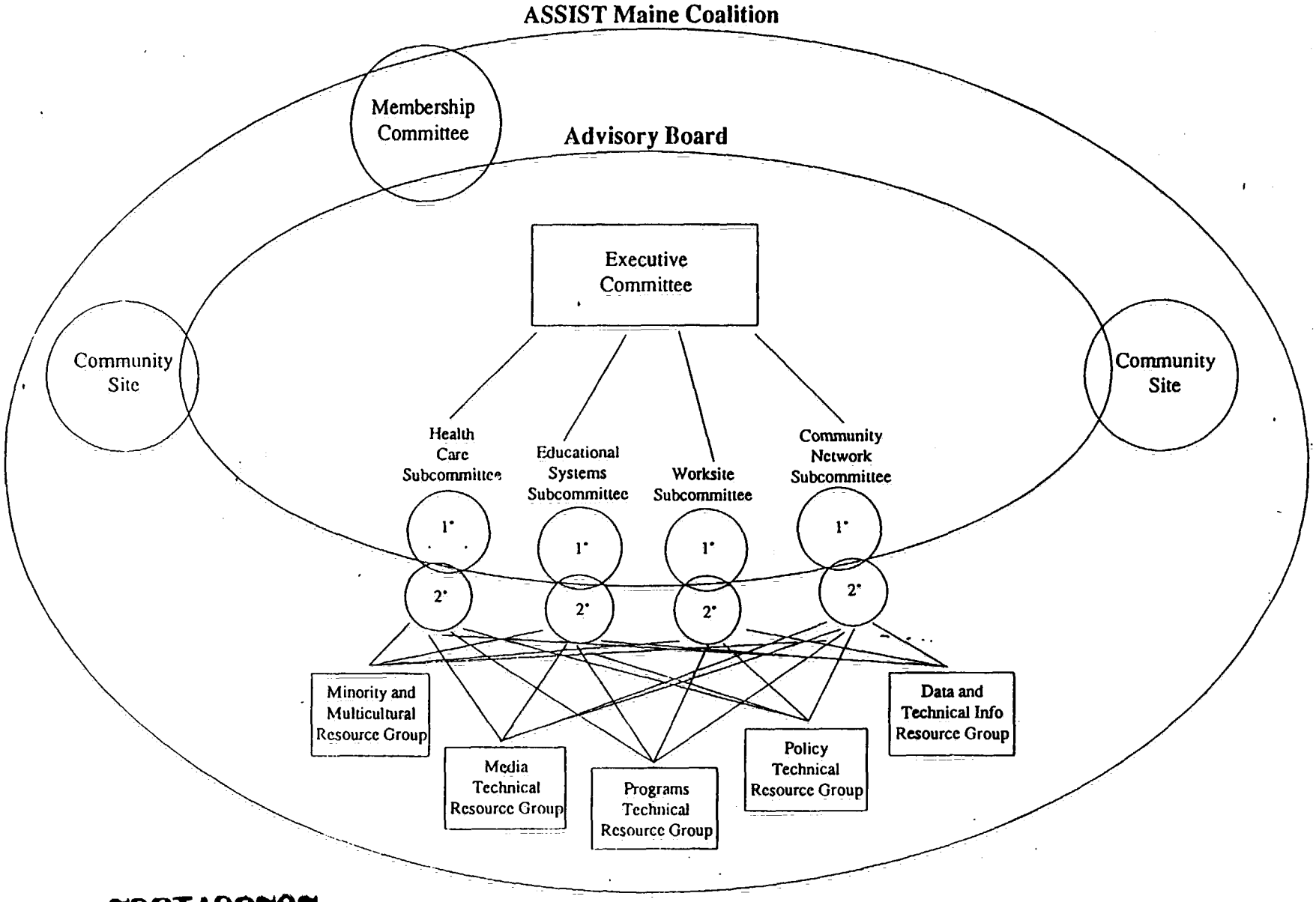

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A structure was presented that provides for subcommittees and technical resource groups. The "Guide to Public Health Practice: State Health Agency Tobacco Prevention and Control Plans" supports this structural decision:

> "As the components needed for a comprehensive tobacco prevention and control plan are developed, the amount of time and work needed will be more than any one group or coalition can give. Subcommittees or task forces can deal with specific parts of the overall plan, draft objectives and outcomes for their portion, and provide the results of their work along with recommendations to the coalition for adoption. By allocating various tasks to smaller groups, the whole process is accelerated and the plan becomes finalized and operative much sooner. It also allows for broadening the plan's participation base and getting input from groups or interests not represented in the larger group" (ASTHO/NCI 1989).

The subcommittee structure will involve a primary subcommittee and a secondary subcommittee network. The primary subcommittee will include all those organizations and individuals with a strong interest and/or active working relationship to a specific channel. It may include members who are new to tobacco prevention and control but, important for the goals of ASSIST or interested in getting more involved. The primary subcommittee will have major responsibility for the smoking prevention and control workplan for its specific channel which will necessitate a more intensive involvement.

The secondary subcommittee will include those organizations with an interest in ASSIST, individuals or groups from specific target groups and those with less direct or intensive interest. They will receive information about ASSIST through newsletters and other communications. The involvement of secondary subcommittee members will hopefully increase over time as they gain a greater understanding of the need for a comprehensive public health approach to tobacco prevention and control.

Coalition Structure

The structure of the Maine ASSIST Coalition is presented below. Numerous organizations have committed to be active participants in the Coalition. Organizations will naturally have differing levels of involvement which the structure allows for. A diagram (p. 146) is followed by a detailed explanation of the structural components.

1. The membership of the Maine ASSIST Coalition is designed to address the target populations through specified intervention channels and settings. Although numerous organizations and individuals have committed to participation in the ASSIST Project, continuous attention will be paid to membership recruitment to cover gaps in the existing structure and to membership retention to make certain that participating groups continue to participate, to maximize likelihood that all relevant parties are involved, and to continuously revitalize efforts.

The Maine ASSIST Coalition is designed as a broad, diverse group consisting of many members in order to impact the tobacco problem in every aspect of community and social life. However, in order to accomplish the necessary tasks in planning and intervention the Coalition involves the following subcommittees.

Subcommitt

The subcommittee structure is designed around the intervention channels. However, each subcommittee will design workplans to explicitly reach target groups).

The Maine Project ASSIST proposes a detailed coalition structure that will be coordinated by Project staff. Subcommittees and technical resource groups are proposed to address various issues in the site analysis and intervention plan development. As depicted in the ASSIST Maine Coalition diagram, the following subcommittees are proposed:

- Health Care System Subcommittee
- Educational Systems Subcommittee
- Worksite Subcommittee
- Community Networks Subcommittee

Each subcommittee will be staffed by Project ASSIST staff or staff of the Division of Health Promotion and Education who will contribute staff time on an in-kind basis. Each subcommittee has roles and responsibilities which are described in Section V and Section VI of the Technical Proposal. The charge for each subcommittee is described in the Technical Proposal (pages 148-152) and excerpts are presented below.

Health Care System Subcommittee

Health care providers, their professional associations, health care facilities and their staff can have a significant impact on tobacco control (cessation), prevention in youth (USDHHS 1987b) and leadership in tobacco prevention and control policy issues. Research has shown that physicians play an important role in helping smokers stop through clinical interventions (Glynn and Manley 1989) and in providing leadership for tobacco control advocacy.

The charge to the Health Care Systems Subcommittee will be to develop a plan to:

- Influence health care providers to promote smoking interventions and to play a leadership role in community smoking control efforts
- Establish delivery of a brief smoking cessation intervention as a minimal standard of practice
- Assist interested professionals in becoming proficient in providing smoking cessation assistance
- Direct smokers to health care providers who are skilled in smoking cessation techniques
- Change health care facility and organization norms to support non-smoking
- Increase adoption and effective implementation of comprehensive health care facility non-smoking policies
- Increase smoking control messages within health care media

Selected members include:

Maine Ambulatory Care Coalition
Maine Consortium for Health Professions Education
American Lung Association of Maine
American Cancer Society of Maine
Maine Public Health Association
University of New England, College of Osteopathic Medicine
Various Medical Associations

Pat Jones, Public Health Educator in the Division of Health Promotion and Education will staff this subcommittee. Members for this group have been selected for their ability to influence tobacco prevention and control programs and policy through the health care system.

Educational Systems Subcommittee

The Educational Systems Subcommittee will develop the plans and intervention strategies for school-based smoking prevention and control activities carried out through private and public primary, secondary and post-secondary schools (USDHHS 1990a).

Educational systems-based interventions impact (a) curriculum, (b) school environment and (c) policies (USDHHS 1987b). Although primarily addressed toward school children, adolescents and adult learners, the school serves as a setting for worksite health promotion for faculty and staff [How healthy are your schools (Drolet 1985)] and as a focal point for community activity.

The charge to the Educational Systems Subcommittee will be to develop a plan to:

1. Delay and decrease the onset of smoking among students.

2. Increase smoking cessation among students, faculty, and staff.

3. Increase the capacity for schools to serve as effective resources for smoking prevention and cessation.

4. Increase adoption and effective implementation of comprehensive school non-smoking policies.

5. Enhance support for non-smoking in PTA's, school-related unions, and other school-based organizations.

The subcommittee will be chaired by Jan Hitchcock, Ph.D. Dr. Hitchcock is a research psychologist with extensive research experience in prevention of smoking in youth. She is formerly the Associate Director of the Institute of Smoking Behavior and Policy at Harvard University. Members of this subcommittee have been selected due to their extensive experience in working with educational systems, knowledge of prevention of smoking in youth, or ability to influence the educational systems to promote policy changes. Selected members include:

- Jane Ann McNeish, Prevention Coordinator, American Lung Association of Maine
- Department of Educational and Cultural Services, Division of Alcohol and Drug Education Services
- Maine School Boards Association
- Maine School Health Education Coalition
- Maine Elementary Principals Association

Pat Jones, Public Health Educator, will staff this subcommittee. Ms. Jones has experience in linking community health education and school health education. She served as staff of the Cessation Resources subcommittee of the Governor's Commission on Smoking OR Health.

Worksite Subcommittee

Worksites are an important channel for health promotion in general and specifically for tobacco prevention and control (USDHHS 1985a and 1985b). The National Cancer Institute states, "worksites are an important channel for smoking control because they represent a setting in which large numbers of smokers may be reached and in which smoking control activities may be promoted, cessation programs offered, and cessation attempts encouraged and supported. Worksites also are an important channel for involving non-smokers in smoking control efforts, particularly through the promotion of non-smoking policies." The National Survey of Worksite Health Promotion Activities (USDHHS 1987a) indicated that smoking control was the most frequently cited category of health promotion activity (35.6% of worksites). However, at 35.6 percent, there is still room for increased activity in this channel.

The charge to the Worksite Subcommittee will be to develop a plan to:

1. Increase cessation among workers who smoke.

2. Increase the capacity for worksites to serve as effective agents of smoking control.

3. Increase adoption and effective implementation of comprehensive worksite non-smoking policies.

4. Enhance support for non-smoking in the business and labor sectors of the community.

The Worksite Subcommittee will be chaired by Sarah MacColl who has extensive experience in worksite health promotion. Ms. MacColl is the coordinator of the Wellness Council, Healthworks and the Portland Public Library HealthShare Program. She is President of the Board of the American Lung Association of Maine. Members of this committee are selected because of their extensive experience in worksite or occupational health, or because of their ability to provide leadership in influencing worksite health promotion and tobacco control policies. Selected members include:

- Bath Iron Works
- Bureau of State Employee Health
- Maine Labor Group on Health
- American Lung Association of Maine
- American Cancer Society, Maine Division, Inc.
- American Heart Association of Maine
- Bureau of Employment Security

Community Networks Subcommittee

A number of studies and programs indicate the strong influence of community and social networks in supporting health behavior change. The large community heart disease prevention programs such as the Pawtucket Heart Health Program and the Minnesota Heart Health Program

(Mittelmark, et al. 1986 and Lefebvre, et al. 1987) have provided evidence of the importance of comprehensive community involvement in health behavior change. A number of social and cultural forces influence the decision to initiate smoking or the decision to quit (Erikson 1988, and Syme and Alcalay 1982).

According to the National Cancer Institute, "community networks are an important channel for smoking prevention and control because they provide an opportunity to reach individuals who may not be reached through health care settings, worksites, or schools" (USDHHS 1989b). Those individuals at high risk, but unreachable through other channels, such as school dropouts, may be addressed through other community networks.

The charge to the Community Networks Subcommittee will be to develop a plan to:

1. Increase cessation among network members who smoke.

2. Build the capacity of community networks to serve as effective agents of smoking prevention and control.

3. Increase adoption and effective implementation of comprehensive non-smoking policies where appropriate.

4. Enhance support for non-smoking in community networks.

The Community Networks Subcommittee will be chaired by Edward Miller, MSEd, Executive Director of the American Lung Association of Maine. Mr. Miller has extensive experience in tobacco prevention and control at all levels. He was formerly the Director of the Division of Health Promotion and Education in the Maine Bureau of Health in which he played a central role in integrating tobacco control into the Bureau's work, has served as subcommittee chair of the Prevention and Youth Subcommittee of the Governor's Commission on Smoking OR Health, is a founding member of the Maine Coalition on Smoking OR Health, has delivered smoking cessation interventions at a rural health center and has trained group leaders in smoking cessation.

The Community Networks Subcommittee will be staffed by the ASSIST Field Director (to be named).

In addition, three specific workgroups will be convened to provide oversight, consultation and technical assistance on interventions utilizing (a) media, (b) policy and (c) program services in each of the intervention channels. Two additional workgroups will be convened, (a) the Data and Technical Information Group and (b) the Minority and Multicultural Resource Group. Each subcommittee will have volunteer chairpersons and members and will be staffed by project staff.

Each community intervention site will establish an analagous local coalition structure. A Field Coordinator (Public Health Educator II) will be assigned to each local intervention site and will serve as the primary staff person. Where possible, the Field Coordinator will have, on-site office space. The Field Directors (Public Health Educator III) and Project Manager will provide oversight and directions to the Field Coordinators in their work with the local site. In addition, of the 2.75 FTE Field Coordinators, one person (FTE to be determined) will be assigned to work with a Field Director to implement the Project statewide in areas other than the intensive intervention sites. An ASSIST specific staff organization chart will be presented below. The ASSIST Advisory Committee links the Executive Committee, the

subcommittees a. Resource Groups, the Community I. ervention sites and the overall Maine ASSIST Coalition. As stated on Technical Proposal page 158-159, it is the mediating body which:

(a) provides advice to the Executive Committee on project policy issues.
(b) links the activities of the committees and resource groups.
(c) forms the link for communication and coordination with the larger Coalition.

The Advisory Committee will include the following:

1. The Executive Committee members
2. Two representatives from each community intervention site
3. The chairperson of each subcommittee
4. The chairperson of each resource workgroup
5. Five at large members.

The Advisory Committee will meet quarterly. The agenda will be set to include:

1. Executive Committee report including NCI ASSIST information
2. Community Intervention Site report
3. Subcommittee and Technical Resource Group report
4. Necessary informational, educational or consultation session (with guest faculty, consultants, or presentations as necessary or appropriate)
5. Time for subcommittee interaction and plan development
6. Other.

The Project Manager and Administrative Assistant will provide staff support to the Advisory Committee. The Administrative Assistant will work with all committees and resource groups to provide logistical support.

Each structure identified in the Maine ASSIST Coalition has defined roles and responsibilities. These are detailed in Section V and VI of the Technical Proposal. In addition to the subcommittee charges identified above, the Management Plan (Section V) indicated the following roles for the subcommittees. (All page numbers refer to the original Technical Proposal (page 124) 5.2.3 Task 3: Site Analysis

The Maine Project ASSIST staff will coordinate and work with the Project ASSIST Coalition through its subcommittee structure... The Project ASSIST Coalition subcommittees will be charged with developing plans for their respective intervention channels. The Technical Resource Groups will provide technical assistance and consultation to the subcommittees for plan development. The subcommittees will include site analysis and plan development as standing items throughout Phase I... Subcommittees will produce and develop the draft by Month 6 of Phase I. It will be reviewed by the Advisory Committee in Month 6, submitted to the Executive Committee after the Advisory Committee review, and approved for final submission by the Executive Committee in Month 8 of Phase I.

The Coalition through the subcommittee structure will develop the Comprehensive Smoking Control plan. The Technical Proposal indicates (page 125), "As in the Site Analysis process, each subcommittee will

develop the draf_ orkplan for its respective interven_ channel...(page 127)...The draft plan will be developed through the Maine ASSIST Coalition structure - subcommittees develop the plan with the assistance of the Technical Resource Groups. The draft plan will be submitted by the subcommittees to the Advisory Committee by Month 13, Day 1. The Advisory Committee will review and comment on the draft plan, the subcommittees will then revise based on the comments. The Advisory Committee will submit the draft plan to the Executive Committee for approval by Day 1, Month 15. The Executive Committee will approve the draft and submit the draft plan to the NCI Project ASSIST Officer by Day 1 of Month 16.

Based on draft review and comment by NCI staff and Maine ASSIST staff, the final plan will be submitted to the NCI Project ASSIST Office by Day 1 of Month 21 in Phase I. The approved plan will be widely distributed and promoted throughout the site. NOTE: The above activities (site analysis, comprehensive plan) will be performed by the Maine Project ASSIST Coalition through its subcommittees, Advisory Committee, Executive Committee and technical resource group structure. Maine Project ASSIST staff will provide all staff support to these activities including coordination and logistic support for meetings, collection of information necessary for development of the analysis and the plan as well as provision of the information in succinct form for coalition consideration, production of plan drafts and revisions and production of the final products. The Maine ASSIST Project Director will provide overall direction and supervision to this process. The Project Manager will provide direct supervision and coordination for all aspects of the above activities, including supervision of project professional staff in their work on the activities, and supervision of project support staff in the production of the site analysis and comprehensive plan. The Field Directors and Field Coordinators will staff subcommittees and provide direct support to community intervention sites.

In Phase II, staff will continue to work with all functional subunits of the Maine Project ASSIST Coalition as detailed in the Management Plan based on Phase I activity - site analysis and comprehensive plan development.

A revision of the technical proposal deletes the subcontract for training coordination with the University of Southern Maine. Based on the recognition of the importance of state capacity building, all training activities and associated logistical coordination activities will be coordinated by Bureau of Health Project ASSIST staff. Project staff will work with each subcommittee, technical resource group, the Advisory Committee and Executive Committee, and in conjunction with NCI and ASSIST Coordinating Center staff, develop the training activities for the Maine ASSIST Coalition in Phase I and Phase II. Based on the wealth of knowledge and experience among coalition members, it is likely that many coalition members will be involved in the delivery of training as well. A portion of one of the Field Director's time and a portion of the Administrative Assistant time will be devoted to training coordination activities.

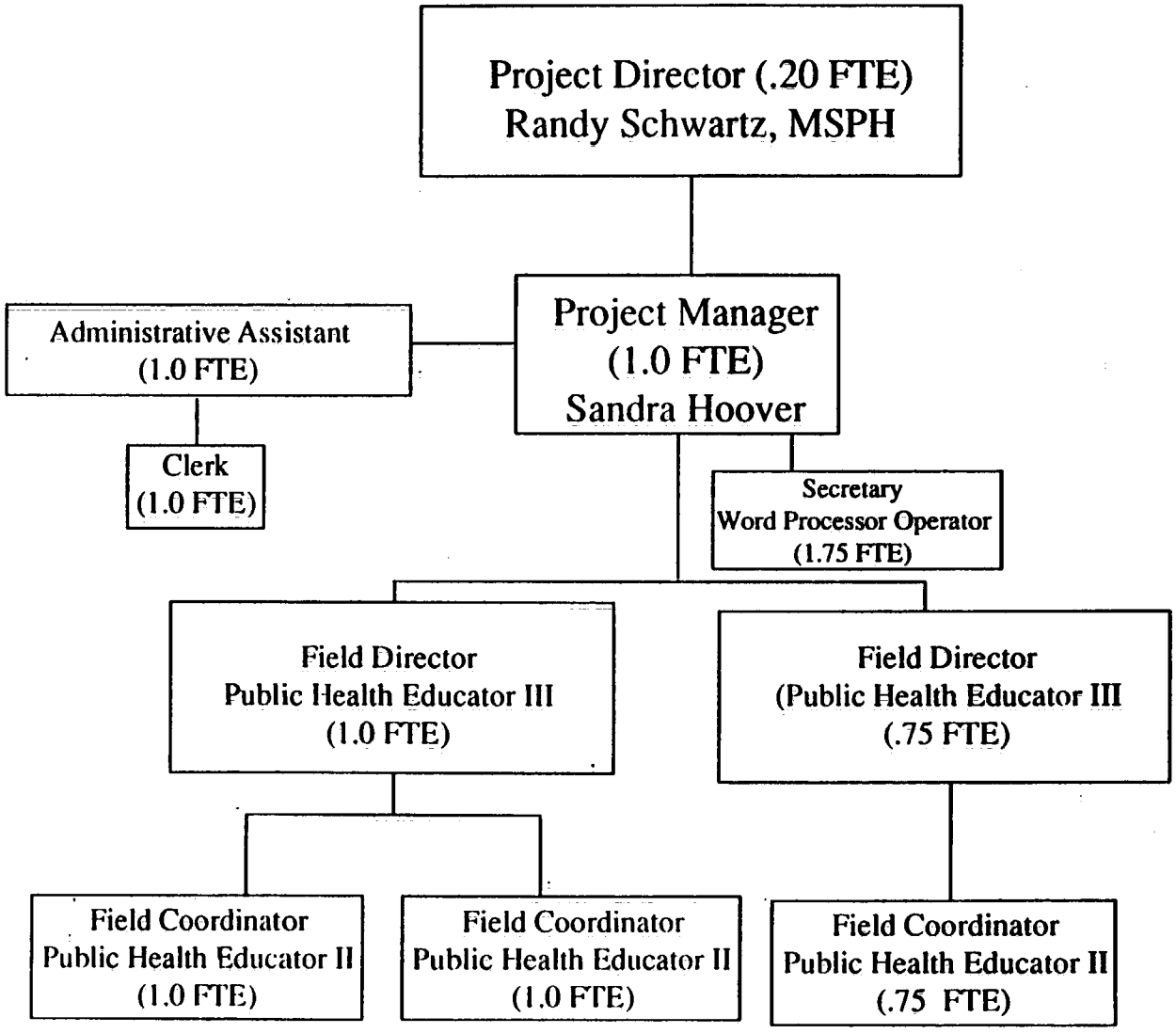
The Project Manager will be responsible for all project monitoring activities as indicated in pages 134-138 of the Technical Proposal. The Expert Review Panel originally proposed will be deleted in recognition that the NCI ASSIST Project staff and Coordinating Center will arrange for such activities. Project coordination and implementation activities as described on pages 138-141 on the Technical Proposal will be performed by project staff in conjunction with various functional subunits of the Maine ASSIST Coalition.

Project staff will coordinate all NCI ASSIST activities with the Maine Coalition. As indicated on Page 139 of the Technical Proposal, "Interventions will be delivered not only by Project staff but by Coalition members' organizations...The intervention plan will detail the respective role of each participating coalition member."

The Annual Action Plan will be developed by Maine Project ASSIST staff in conjunction with all working groups (page 140, Technical Proposal).

The Maine Project ASSIST Director will serve as the chief liaison to the National Project and (page 141) "will attend all Coordinating Committee meetings, serve on project-wide subcommittees, task forces or other project-wide administrative meetings. In the case where the Project Director cannot attend, a representative of the Project will be appointed to attend." In most cases, this will be the Project Manager, Sandra Hoover, PhD, MPH.

Maine Project ASSIST Organizational Chart



Maine Project ASSIST Staff - Major Roles and Responsibilities

Staff Person	Roles/Responsibilities
Project Director Randy Schwartz, MSPH	Overall supervision and direction of project; Primary liaison with NCI and Coordinating Center; Linkages with other parts of Maine state government, Executive Committee member.
Project Manager Sandra Hoover, PhD, MPH	Day to day management of all project activities including staff supervision; coordination of all functional subunits - subcommittees and technical resource groups; management of development and production of site analysis and comprehensive plan and intervention implementing coordination with all organizations, agencies, related to tobacco prevention and control in Maine; acts as representative for Project Director to NCI when necessary.
Field Director (1.75 FTE) To Be Determined	Statewide plan development; community site technical assistance; subcommittee staffing; one or both Field Directors will work on media development, promotion, etc; represent ASSIST to various organizations throughout the state; intervention development and implementation team.
Field Coordinators (2.75) To Be Determined	Direct work with community sites and statewide; staff subcommittees; intervention delivery.
Administrative Assistant (1.0 FTE) To Be Determined	Coordination of logistics for all subcommittees, training events, meetings, etc. Support for senior Project staff and coordination of production of all project products.
Secretary (1.75 FTE)	All clerical duties to support work of Project staff, coalition and various coalition subunits.
Clerk (1.0 FTE)	Data-entry and clerical duties.

Maine Project ASSIST - Coalition - Staff Relations

As indicated above, the Coalition and its varying functioning units will have specific tasks as well as evolving responsibilities as the project progresses. A description of the Coalition and Subcommittee roles was provided above. Below, please find a brief (and not inclusive) listing of Coalition and subcommittee task relations to project staffing.

Task/Role/Responsibility (as detailed in Technical Proposal)	Coalition Unit	Staffing
• Site Analysis - Development • Comprehensive Plan -	Subcommittees: • Healthcare • Educational Systems • Worksite • Community Networks	Overall supervision by Project Manager, committees, staffed by Field Directors, Field Coordinators, ACS staff and other Maine Division of Health Promotion and Education staff as appropriate and necessary.
• Site Analysis and Comprehensive Plan Development - Consultation	Workgroups and Technical Resource Groups: • Data and Technical Information • Minority and Multicultural • Media • Policy • Program	
Site Analysis and Comprehensive Plan - Review, Comment, Revise	Advisory Committee	Project Manager, Field Directors
Site Analysis and Comprehensive Plan - Approval, Production, and Submission to NCI	Executive Committee	Project Director, Project Manager, all ASSIST staff
Communication of Projec.	All Coalition Units	Project Manager, Field Directors, Field Coordinators

Media Development and Promotion	All Subcommittees • Media Workgroup • Data and Technical Information • Minority and Multicultural Resource Group	Project Manager, Field Director(s), Field Coordinator(s)
Community Intervention Site	• Community Intervention sites Coalitions • Advisory Committee • Data and Technical Information Workgroup	Overall supervision by Project Manager; Field Coordinator(s); Field Director(s)
Training - Development, Delivery, Participation	All Units and Subunits of Coalition	All Staff

State of Maine

Technical Questions

Factor 1: Management Approach

Question 2: The RFP requested that offerers propose concentrated intervention regions for ASSIST. However, given that ASSIST sites must plan to achieve a 43% reduction in smoking prevalence from 1985 levels throughout the entire site, please describe the proposed methods for reaching the entire State.

This question addresses the very heart of the ASSIST Project both nationally and Maine's proposed approach. The Maine Project ASSIST proposed coalition structure and process, and its management plan, both as described in the Technical Proposal and clarified below, are explicitly designed to address the entire State and the two proposed intervention sites concurrently.

The ASSIST RFP requested a structure that would provide for Phase V Cancer Control research - the dissemination phase. The RFP indicated (page 34) that "through these coalitions, smoking control efforts will be directed toward reaching all smokers, with particular emphasis on target populations wherein smoking remains a problem requiring special attention. Such groups include:

- youth
- ethnic minorities
- women
- blue collar workers
- less educated individuals
- smokeless tobacco users"

And that these target groups be reached through diffusion channels:

- worksites
- health care systems
- schools
- community networks
- community environment

With interventions:

- media
- policy
- program services

The NCI Standards for Comprehensive Smoking Prevention and Control (Appendix A of the RFP) provide the blueprint for the above. A pictorial representation of the model is presented in RFP Figure 1, Planning Model for Smoking Prevention and Control (page 4 of the standards, RFP page 61). The Maine ASSIST Project will apply these standards vigorously and thoroughly so that each smaller cube of the cube presented in figure 1 is reached, allowing for deep diffusion of the standards throughout every channel, network and aspect of Maine life.

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This is revie . below by detailing how the target pups, channels and interventions above are addressed statewide through Maine's proposed coalition structure and management plan. In fact, the NCI standards are integrated into the coalition structure and management plan as originally proposed.

The coalition structure and process combined with such broad intervention diffusion techniques as mass media and policy changes are an important aspect of reaching the entire State.

As described in Section VI of the original Technical Proposal (and in response to Question 1 above), a very comprehensive and functional Maine Project ASSIST Coalition is proposed. The Maine Project ASSIST Coalition is designed to reach the entire State, with analogous community coalitions developed in the two intervention sites. The design of the Maine Project ASSIST Coalition, as well as the diverse membership, will enable Maine's Project ASSIST to reach and permeate all channels of Maine life with smoking prevention and control media, policies and programs.

In order to illustrate the potential for widespread and deep diffusion utilizing the proposed coalition structure, several examples are presented below.

Most, if not all, members of every unit of the proposed Maine Project ASSIST Coalition represent not only themselves or their immediate organization, but a network of organizations or individuals with the diffusion potential or reaching hundreds or thousands of people with tobacco prevention and control interventions (media, program, policy - or any combination of these).

The Maine Project ASSIST Coalition was proposed in Section VI and is illustrated in the attached diagram. The Coalition proposed is a statewide coalition (in response to this question), thus the subcommittees, technical resource groups, Advisory Committee, etc. will be doing a state site analysis and statewide comprehensive plan. The Community intervention sites will do the same for their local intensive interventions.

For example, the Coalition's Worksite Subcommittee will apply the NCI comprehensive smoking prevention and control standards in large and small worksites throughout the state. This was indicated on pp. 150-151 of the Technical Proposal. To illustrate the potential diffusion of interventions through this subcommittee's work, in relation to the statement above (that membership on the various subcommittees and workgroups has an effect way beyond the members or even their own organizations), the selected members indicated on page 151 will, through the participation of specific representatives reach thousands of worksites: The Bureau of State Employee Health provides health promotion programs for 15,000 workers; participation of Bath Iron Works (a large shipbuilder) and their occupational health physician Dr. Parotte will provide entry to 12,000 workers. Thus, the two largest worksites reaching 27,000 workers are represented, committed to the project and will diffuse the interventions through their sites. The Maine Project ASSIST will do an inventory of all the largest worksites (up to the top thirty to fifty largest) and involve all to the degree possible. The Maine Labor Group on Health represents organized labor - thousands of workers. Their participation will reach many thousands of workers through organized labor health and safety training. The Wellness Council in Portland is a coalition of businesses organized to help employees implement and/or enhance worksite wellness programs. They reach 20,000 employees in 22

worksites in Portland. The Council Executive Director will chair the Worksite Subcommittee. Thus, as an illustration, through just a few of the members of this subcommittee, many worksites and about 50,000 workers (plus their dependents) are reached.

The Educational Systems Subcommittee will potentially reach: every school district in Maine, the Vocational Technical Institute system (important for blue collar workers target population), school boards (important policymakers), PTAs, etc. For example, the participation of the Department of Education's Division of Alcohol and Drug Education Services provides a linkage with one-hundred (100) school-community chemical free teams throughout the state as well as hundreds of school-based substance abuse counselors. The Maine School Boards Association and Maine Elementary School Principals Association similarly link with representatives from each and every school district. Thus, the subcommittees' activities will reach thousands of students, school system employees, etc.

The Community Networks Subcommittee will include representatives for the Boy Scouts (statewide network reaching thousands of youth), and the University of Maine Cooperative Extension (presence in every county and community with numerous target groups). The Christian Civic League provided a letter of commitment, as did the Roman Catholic Diocese Pastoral and Educational Services. The Christian Civic League represents 4500 families and 231 churches. An inventory will be completed for all community network organizations in Maine. Thus, this subcommittee will apply the NCI standards to hundreds of organizations and networks reaching tens of thousands of people in the State.

To complement all of the above, the Maine Project ASSIST will be implementing extensive media and policy interventions. This will affect the community environment and will reach thousands of people with written, radio and TV broadcast messages promoting the nonsmoking message.

The combination of all of the above interventions applied in a planned approach according to quality standards provided by the National Cancer Institute will enable the Maine Project ASSIST to reduce the smoking prevalence by 43% statewide.

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Technical Questions

Factor 1: Management Approach

Question 3: Please provide a narrative description of the subcontractor's roles and responsibilities, activities, and costs. Describe in detail how the proposed work of the subcontractor is consistent with the Statement of Work.

Based on a review of the Statement of Work, a recognition the importance of capacity building for state health agency tobacco prevention and control and discussions with NCI staff, the decision has been made to delete the subcontract from the proposal. Bureau of Health ASSIST staff will assume all duties previously designated to the subcontract staff. The project will still be able to purchase such items as air time on the interactive television system from the University of Maine through intervention monies.

As a result of this management decision, revisions have been made accordingly to the Management Plan, Section V, and to the Business Proposal.

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Technical Questions

Factor 1: Management Approach

Question 4: Please Provide a brief description of the basis for choosing the target groups to receive intensive intervention.

Target groups were selected based on the following criteria: (1) smoking prevalence; i.e. high smoking and smokeless tobacco use rates; (2) those at risk for starting to smoke; and (3) those having limited access to smoking prevention and control information and services. Specific groups for each of the criteria are summarized below.

1. Smoking Prevalence:

Women/Pregnant Women:

As indicated in the technical proposal, Section III, The Smoking Problem, "the number of women smoking is decreasing more slowly than it is for men. The most recent data indicate that smoking prevalence is now higher among women than men in the state (Maine Department of Human Services, 1990b). These are troubling statistics, indicating that, anti-smoking messages are reaching men but not women. Even more troubling is the preponderance of female smokers in the age groups under 45, the prime childbearing years.

Data from the 1988 PRAMS survey indicate that smoking during pregnancy has greatly elevated the number of low birthweight (birthweight of 2,500 grams or less) babies. Of women who bore low birthweight babies, 41.4% reported smoking during pregnancy. In contrast, of women who bore normal birthweight babies, 25.2% reported smoking.

Data from WIC (the federal food supplement program for women, infants and children) eligibility screenings (August, 1987 to December, 1988) indicate smoking prevalence of 41% to 43% in pregnant women. The Director of the Division of Maternal and Child Health indicates this rate may now be as high as 48%. Since Maine has the sixth highest rate of pregnancy among white teens in the nation, one can extrapolate that many of the smoking, pregnant WIC clients are also under the age of 20.

Maine has a significant problem with smoking among women, and especially among pregnant women. This problem is exacerbated by poverty and youth."

Young Adults:

As noted in the proposal (p. 62), "According to BRFS data, the prevalence of current smokers aged 18-34 (32.8%) ranks third in the nation, surpassed only by Tennessee and Kentucky. The proportion of persons aged 18-34 "who ever smoked" (53.1%) ranks first in the nation (Centers for Disease Control 1989).

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Youth:

This group falls under Criterion #2, however it is important to note that according to the 1989 Maine Youth Tobacco Use Survey, 23.1% or nearly one quarter of all students were smokers. This does not include those who have dropped out of school (p. 65).

Less educated individuals:

As noted in the proposal, "Maine residents with lower levels of education generally smoke more than those who attended more school. This is consistent with data on the inverse relationship between educational attainment and smoking status reported in the 1989 Surgeon General's Report (USDHHS 1989c and Pierce et al. 1990) Maine BRFS data has shown variability within certain educational levels from year to year, especially among four categories: educational attainment of less than 9th grade, some technical school, technical school graduate, and post college education. Some of this variability is due to smaller subsamples in these groups.

Mainers who have graduated from high school or attained lesser levels of education smoke slightly less than their counterparts nationally, and those with college and graduate education smoke slightly more.

According to Maine BRFS data, the quit rate among male smokers in Maine varies from 29% to 36% for those with a high school education or less, and from 34% to 37% for those with education beyond high school. Among women, there is a striking separation at the cutoff of high school graduation. Female smokers with a high school education or less have quit rates from 14% to 22%, whereas those with education beyond high school have rates from 24% to 29%. Thus, the quit rate among more highly educated Maine women is up to twice that among the less educated (USDHHS 1989c).

In 1988, 3.76% of Maine's 9th through 12th graders dropped out of school. Among all adults in the state (Maine Department of Human Services, 1990b) 18.2% had not graduated from high school. The smoking rate among dropouts under the age of 18 is not being measured by any of the systems currently in place. It is likely to be quite high, if Maine follows national trends."

Blue Collar Workers:

As reported in the proposal, "the 1983 report, Smoking in Maine, based on data from the 1980 Hypertension Household Survey gives analysis of smoking prevalence data by occupation. Those employed in sales, blue collar jobs, and farming, fishing, and forestry had higher smoking rates than did those in professional and technical jobs. In professional and technical jobs males had smoking rates of 27%, and females 28%. In contrast, in sales, blue collar, and farming, fishing and forestry males had smoking rates from 41-67%, and females from 48-56%. These data are consistent with national trends that show blue collar workers with higher smoking prevalence than white collar workers (see graph below).

The Surgeon General's 25th anniversary report lists national smoking prevalence (based on 1985 data) among white collar workers as 26.4% for males and 28% for females, whereas prevalence among blue collar workers is 40.1% and 33.9%, respectively.

Also, consistent with national data, unemployed persons in Maine have higher smoking prevalence rates than those in other employment categories. Most notable is the rate among those who have been unemployed for less than one year (prevalence of 42%), which is 50% higher than the state average (prevalence of 27%).

Table III.3
Estimated Percent at Risk for Smoking by Employment Status

	Estimated Percent at Risk	Approximate 95% Confidence Interval
Employed	30%	27% to 32%
Self Employed	28%	22% to 33%
Unemployed < 1 Year	33%	17% to 50%
Unemployed > 1 Year	42%	28% to 55%
Homemaker	33%	28% to 39%
Student	20%	8% to 33%
Retired	15%	12% to 18%

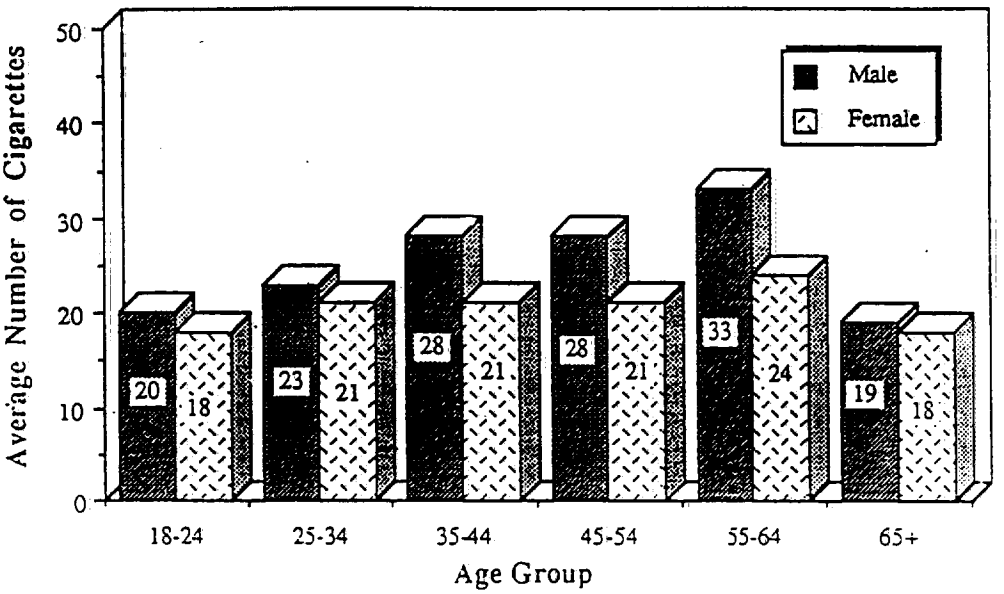
Source: Maine Department of Human Services, 1990b

Maine residents with low incomes generally tend to smoke more than those with higher incomes. This trend is congruent with higher smoking prevalence among those with less education and among those with blue collar jobs. Smoking prevalence rates by income have remained relatively steady in the past three years, 30% for those with incomes under $20,000, 26% for those with incomes of $20,000 to $35,000, and 22% for those with incomes of $35,000+."

Heavy Smokers:

As noted in the proposal, "the heaviest smokers in Maine according to data (Maine Department of Human Services 1983) are men aged 55 to 64, who had an average daily consumption of 33 cigarettes. Other age groups of men vary in average consumption from 19 to 28 cigarettes per day. As can be seen in the figure below, the average daily cigarette consumption of women of all ages is lower than that of men. Women's average consumption also varies less by age than does men's. The large drop in daily consumption rates for men ages 55-64 and ages 65+ may be due to earlier mortality and morbidity among the heaviest smokers (e.g., by the age of 65 and older, only lighter smokers still are living).

Average Number of Cigarettes Smoked Per Day By Age Group and Sex



Source: Maine Department of Human Services, 1983

Of current smokers in Maine in 1986, 71% reported smoking less than one pack (20 cigarettes) a day. This was essentially equal to the national rate in 1985 with 73% of smokers reporting smoking 24 or fewer cigarettes per day. The proportion of smokers nationally categorized as "heavy" smokers (25 or more cigarettes per day) did not change significantly from 1974 to 1985. We may assume that the pattern among Maine smokers is similar, although such data are not available."

Smokeless Tobacco:

The technical proposal points out that "according to 1986 Maine BRFS data, 3.4% of males had ever used or tried smokeless tobacco, as had 0.6% of females. In 1987, 2.7% of males reported current use of smokeless tobacco; in 1988, 1.6% reported such use. The 1987 usage figure is comparable to 1986 data for the northeast region which showed use by 3.0% of males (USDHHS 1989c). It is also comparable to data from the Current Population Survey, (Marcus et al. 1989) which indicate that among males aged 16 years and older, 2.3% use smokeless tobacco, compared to 5.5% in the United States.

Smokeless tobacco use tends to be a much greater problem among young males in Maine. Use in this group was measured by the Maine Youth Tobacco Use Survey in 1987 and 1989, as can be seen in Table III.6.

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Table III.6
Smokeless Tobacco use by Grade Level

grade	5	7	9	12
1987	1.1%	2.1%	4.2%	4.6%
1989	1.5%	4.0%	6.0%	8.7%

Source: Tri-Agency Tobacco Free Project, 1989

Smokeless tobacco use among Maine youth has increased over the past two years and is beginning at younger ages.

As mentioned previously, use in the Northeast (as compared to the rest of the nation) tends to be lower, and in Maine the rates for males age 18 and older is comparable with this regional rate. However, use among Maine's high school seniors is nearly 9%, a rate comparable with the nation. One would expect a relatively lower rate among Maine youth to correspond with the lower regional rate. Of great concern is the concurrent use of smokeless tobacco and smoking reported in the Tri-Agency Youth Survey.

High school-aged males in Maine have a significant problem with use of smokeless tobacco. The problem is growing and must be addressed. It is important to note again that the Youth Tobacco Use Survey reaches only young persons who are in school. Dropouts are not included in the figures, and they are likely to be at even greater risk."

2. Those at risk for starting to smoke:

Youth:

As reported in the proposal, "the Maine Youth Tobacco Use Survey, a joint smoking prevention effort of the American Cancer Society, Maine Division, Inc.; American Heart Association, Maine Affiliate, Inc.; and the American Lung Association of Maine; was designed to obtain current specific data on the prevalence of tobacco use among teens. Twenty-eight thousand fifth, seventh, ninth and twelfth grade students from 72% of all public and private schools responded to the survey in 1987 and 22,174 students responded in 1989.

In 1987, smoking rates for boys and girls were the same, 12.6% of the students responded as current smokers. The smoking rates increase between grades seven and nine from 8.6% to 17.7%. As might be expected, fewer grade five students smoke (3.1%), whereas more grade twelve students smoke (23.2%). Nearly 30% who have tried smoking have quit. Smokeless tobacco use was reported by 7.8% of ninth grade boys, and by 8.3% of twelfth grade boys. Of those who use smokeless tobacco, 45% also smoke cigarettes.

In the 1989 survey 11.2% of students (12.6% in 1987) were smokers. Smoking occurred among 2.6% (3.1% in 1987) of 5th graders, 9.7% (8.6% in 1987) of 7th graders, 16.9% (17.7% in 1987) of 9th graders, and 23.1 (23.2% in 1987) of 12th graders. Thus, by the last year of school almost one-quarter of all students were smokers. Since this is only the second survey, no trend analysis is possible. This survey will be repeated every two years to identify trends.

Of the four grades surveyed in 1989, 10.2% of females (12.7% in 1987) and 12.0% of males (12.5% in 1987) reported smoking. Significant differences, however, were found in smoking rates among the 16 counties. Of the current smokers (2.3%) had not yet smoked 100 cigarettes. Seventy-one percent of all students reported being bothered by smoke.

Table III.1
Smoking by Grade and County, 1989

COUNTY	GRADE			
	5	7	9	12
Androscoggin	2.1	11.4	13.7	18.0
Aroostook	2.7	11.3	13.6	24.8
Cumberland	2.5	7.6	23.5	26.1
Franklin	2.3	13.3	15.9	*
Hancock	4.3	6.5	11.7	16.9
Kennebec	2.6	9.0	18.3	22.7
Knox	3.6	12.2	10.2	19.0
Lincoln	2.9	6.5	16.5	23.3
Oxford	3.5	9.3	22.8	26.7
Penobscot	2.2	6.2	15.6	24.3
Piscataquis	1.6	10.0	19.0	*
Sagadahoc	4.2	18.6	21.4	*
Somerset	2.4	15.7	19.9	22.1
Waldo	1.0	2.3	24.6	22.6
Washington	6.1	15.6	19.2	16.3
York	1.4	7.4	15.5	21.9
State	2.6	9.7	16.9	23.1

* *Insufficient Data*

Source: Tri-Agency Tobacco Free Project, 1989

Two and six-tenths percent of the survey population used smokeless tobacco products while 6.0% of 9th grade boys and 8.7% of 12th grade boys used smokeless tobacco at least once a week. As with smoking, the percentage of chew/snuff users was higher in the upper grades. Smokeless tobacco use did not necessarily replace smoking. Forty-seven percent of youngsters who used smokeless tobacco also smoked cigarettes.

Use of smokeless tobacco varied widely among counties. Higher rates were reported for seniors in Franklin, Oxford, and Washington counties. In Somerset County 4.5% of 5th graders reported weekly use as compared to less than 1% reported in four other counties.

A copy of the full summary report of the Tri-Agency Youth Survey was provided in the Appendix.

Unlike national figures (which show smoking among female high school seniors as higher than that among males) Maine's male high school seniors have a smoking prevalence rate slightly higher than females. This contrasts with the most recent BRFS findings, which show smoking among adult females is higher than that for males.

As found nationally, the overwhelming majority of Maine residents began to smoke when they were teenagers, in the 18-24 age group 96% of the male smokers and 93% of the women smokers. The 1983 Smoking in Maine report indicated that about half of all cigarette smokers in Maine (1980) first acquired the habit during their high school years. Of great concern was the tendency for younger age cohorts to have increasingly large groups who began smoking in the junior high school and primary school years."

Table III.2
Age at Which Smoking Began

MALES

	% Began Before The Age of 12	% Began Age 12-14	% Began Age 15-18	% Began After The Age of 18
18-24	13	28	55	4
25-34	9	13	52	25
35-44	3	15	54	27
45-54	3	20	59	19
55-65	5	19	39	37
65+	6	16	50	27
ALL AGES	6	16	50	27

FEMALES

	% Began Before The Age of 12	% Began Age 12-14	% Began Age 15-18	% Began After The Age of 18
18-24	5	24	64	7
25-34	0	15	54	31
35-44	3	12	62	23
45-54	0	4	60	36
55-65	0	4	40	56
65+	0	8	33	59
ALL AGES	1	11	53	35

Source: Maine Department of Human Services, 1983

3. **Those with limited access to smoking prevention and control information and services:**

Ethnic Minorities (Native Americans and Franco Americans):

The population, as mentioned in The Technical Proposal, Section I, "is primarily white (98.4%). Blacks and Hispanics each represent only 0.3%, while Asians and Native Americans (and others) represent just under 1% of the population. The largest non-white group, according to 1980 Census data, is Native American, numbering 4,087, with 1,430 living on reservations. One reservation is in Penobscot County (Penobscot Tribe) and two are in Washington County (Passamaquoddy Tribes).

The Penobscot Indian Island Reservation has 620 Native American residents. It is a Community Chronic Disease Prevention (CCDP) site, so information on smoking prevalence is available. Over 54% of the residents aged 18 and over smoke, a rate that is double that of the state. The reservation's status as a CCDP site will facilitate participation in the ASSIST program.

Nearly one quarter of Maine residents claim a French ethnic background (Franco-American). French is the primary language spoken in approximately 10% of households. BRFS data from two PATCH sites having a substantial French population (1987 and 1990) show a smoking prevalence similar to the statewide average. However, Franco-Americans are disproportionately represented in such target groups as the lesser educated and blue collar workers.

According to a 1980 survey on Smoking in Maine (Maine Department of Human Services 1983), Franco-American men had a lower prevalence of smoking (34%) as compared to "American only" (38%), while women (identified as French/Canadian/European tended to smoke more often (44%) as compared to "American only" (30%). This group of women was also more likely to be currently smoking than males with similar ethnic identification.

Culturally appropriate strategies and channels will be used to reach both Native Americans and Franco-Americans."

People with low income, high school drop outs, and the unemployed also fall into this category. See Criterion #1.

Note that individual smokers may fall into several of the target groups; for example, young women who have not completed high school and have incomes below the poverty level; Native Americans who are heavy smokers, high school drop outs and have low incomes; Franco Americans who although generally do not have a higher smoking prevalence than other groups, but who tend to be disproportionately represented in blue collar, lesser educated and lower income groups. Special efforts and resources will be directed to those groups where prevalence is high, quit rates are low and access is limited; for example, low income women, those at risk for dropping out of high school and Native Americans.

State of Maine

Technical Questions

Factor 1: Management Approach

Question 5: Please list Federally-funded grants and contracts related to cancer control activities within the site. Describe how these activities will support and complement ASSIST.

There are several Federally-funded grants and cooperative agreements which will be complementary and supportive to the ASSIST Project in Maine. These were indicated in Section VII of the Technical Proposal - State Health Agency Qualifications (pp. 171-194) and in the Business Proposal in Section III, Qualifications of the Offerer, and listed on page 41 and 42 of the Business Proposal under (3) Pertinent Grants and Cooperative Agreements. In addition, a portion of the Preventive Health and Health Services Block Grant (PHHSBG) awarded to the Maine Department of Human Services is utilized for tobacco prevention and control activities which are integrated into other ongoing core activities of the Division of Health Promotion and Education.

The Federally-funded projects of importance to the implementation of ASSIST in Maine are described below.

1. Preventive Health and Health Services Block Grant (PHHSBG)

At least two programs funded by the PHHSBG in the Division of Health Promotion and Education includes tobacco prevention and control. The "Risk Reduction" line (an outgrowth of when the CDC Health Education/Risk Reduction grants were folded into the Block Grant) funds the Division's Community Health Promotion/Chronic Disease Prevention Unit as well as core-funding for Division of Health Promotion and Education activities. The Planned Approach to Community Health (PATCH) program is part of this unit. Several of the communities implementing PATCH include tobacco prevention and control activities as part of the community-based health promotion initiative. Each community has done a Behavioral Risk Factor Survey which includes tobacco use questions. Thus, the experiences of implementing community-based interventions as part of PATCH will be useful in implementing ASSIST interventions in the state and local community intervention sites. In addition, PHHSBG funding is utilized for the Division core tobacco prevention and control activities - information dissemination, PSA distribution, legislation development and testimony preparation, inquiry responses, information and enforcement of the Workplace Smoking Act, and technical assistance activities related to smoking policy development and implementation, community interventions and other activities.

Another program funded by the PHHSBG, the Hypertension and Cardiovascular Risk Reduction Program, includes smoking prevention and control in its communications and community intervention activities. The program funds eight community cardiovascular disease prevention program sites. Each of these programs must include smoking prevention and/or cessation interventions in it's workplan. The program also distributes NHLBI produced PSAs to all television stations in Maine. In conjunction with the major NBC-TV affiliate in Maine - WCSH-TV, the Division of Health Promotion and

Education w. able to initiate a statewide broadc broadcast of the Healthy Heart IQ, a half-hour TV show on three major cardiovascular risk factors - hypertension, elevated cholesterol and smoking. The show was broadcast on the Portland and Bangor NBC outlets allowing total statewide coverage. It was promoted through posters and brochures featuring the Healthy Heart IQ quiz at supermarkets and a restaurant chain throughout the state.

Through funding provided by PHHSBG core funds, numerous tobacco prevention and control initiatives such as those above have provided a strong foundation for tobacco control in Maine.

2. Community Chronic Disease Prevention Program (CCDPP) Centers for Disease Control Cooperative Agreement - Numbers US8/CCU102823 and U58/CCU102635

This program was described in Section VII of the Technical Proposal, State Health Agency Qualifications (pp. 180-181) and in the original Business Proposal (pp. 30-31). Maine was only one of four states to have received a CDC cooperative agreement to implement a community-based chronic disease prevention program focused on reducing risk factors for heart disease and cancer. The Community Health Promotion Program is working with three communities: Mount Desert Island (MDI), the Portland West End Neighborhood and the Penobscot Indian Reservation (Indian Island). The three year cooperative agreement began October 1, 1987. All three communities have hired project coordinators (1/2 FTE), collected baseline data on behaviors, knowledge and program participation concerning heart disease and cancer risk factors, and initiated interventions on smoking, exercise, and nutrition. The third and final year of the project has focused on continuing the intervention activity and on evaluation.

Interventions specific to tobacco use have centered on training of community people and local coordinators to conduct smoking cessation classes, worksite smoking policy development and public education. Most notably, the Penobscots have used data from their Behavioral Risk Factor Survey showing a 54% smoking prevalence on the Island and compared that with other Native American prevalence rates and the general Maine population. In addition, they conducted additional surveys of youth (K-8), seniors and employees of the Health and Human Services Building staff. Using these data and information about health risks especially to children, they have been able to marshall public support for a smoking ban in their Health and Human Services building (the center for a number of activities on the Island ranging from day care to senior lunches). This policy went into effect July 1, 1990 with little public resistance.

The Portland project has successfully established two smokers' anonymous support groups. They have also instituted policies banning smoking at Portland West Neighborhood Council Meetings and in their offices. The Council is comprised of low income representatives of the community. It should be noted that these policies were developed in partnership with community people and voted on at council meetings.

The MDI project has provided self help quit kits as well as conducted smoking cessation classes. The coordinator is currently working with the Island's largest employer, Jackson Lab, to implement their smoke free worksite policy.

This program is currently ending with a no-cost extension year for evaluation purposes.

3. Data-based Intervention Research for Cancer Prevention and Control in Public Health Agencies - National Cancer Institute Cooperative Agreement Number VOL CA 52876-01.

This program began in October 1990, soon after the submission of the proposal for the ASSIST project. The Data-based Intervention Research (DBIR) for Cancer Prevention and Control in Public Health Agencies Cooperative Agreement will have a significant and complementary contribution to Phase I and subsequently Phase II of ASSIST.

The DBIR purpose is to "support projects that will serve as models of data use in the planning, development and evaluation of statewide cancer prevention and control intervention...this use of data should allow health departments to effectively select those cancers and intervention strategies that will have the greatest effect on the public's health and direct those interventions to specific geographic areas or target populations most in need" (from NCI RFP).

Maine's DBIR Project is utilizing the Department of Human Service's Cancer Prevention and Control Advisory Committee (CAPACAC), which was established in statute by the Maine State Legislature, as a focal point for coordinating the four phases of the Project. The four phases are:

Phase I: Appraisal and Analysis of Data

Allows for the identification and appraisal of existing data sources related to the entire state population which are pertinent to the priority areas for cancer prevention and control. Indicators of the quality of the data proposed to be used should be described (up to nine months).

Phase II: Planning

The data are to be reviewed by local experts to assess its importance in the assessment of health needs of the population, and the identified needs and priorities are to be incorporated into an existing cancer control plan or used to develop a new plan (up to nine months).

Phase III: Intervention

Allows for the initiation of new or modification of existing selected cancer prevention and control intervention programs at the state and local level as specified in the plan.

The proposed interventions must include a program focused on informing state legislators of the nature and extent of the cancer problem in the state, the potential that exists for intervention, and the resources required to deal with the problem (up to three years).

Phase IV - Evaluation

Is a follow-up period for three years allowing for a process and outcome evaluation of Phases I through III. Changes in the quantity, quality, and type of control programs and legislative actions arising out of the first three phases will be identified and catalogued including the data used in its value to the total effort.

Subcommittees have been established around four specific content areas - 1. Tobacco Prevention and Control; 2. Early Detection of Breast and Cervical Cancer; 3. Nutrition and Diet Modification for Cancer Prevention and 4. Reduction of Occupational Exposure.

The work of the tobacco prevention and control subcommittee and project staff in DBIR Phase I: Data Appraisal and DBIR Phase II - Plan Development will provide valuable input to the ASSIST Phase I activities. DBIR Phase III - Interventions and Phase IV - Evaluation, will provide valuable information for ASSIST Phase II activities. In addition, the subcommittee will be mobilized and energized to work on ASSIST activities due to its involvement in the DBIR Project.

The tobacco prevention and control objectives in Maine's DBIR proposal include:

Phase I: Appraisal and Analysis of Data

Objective 1: To develop a consortium for appraisal and analysis of tobacco prevention and control data which will continue to provide consultation through all phases of the project.

Phase II: Planning

Objective 1: Enhance the capacity of the cancer advisory committee to provide technical assistance to the Bureau of Health to improve cancer control in Maine.

Objective 2: To present a compilation of data on tobacco use in Maine in both written and verbal presentations.

Prepare a briefing document on current sources of data on tobacco use, and a briefing on intervention approaches; develop strategies for tobacco cessation and prevention for the identified target populations.

Phase III: Interventions

Although the specific interventions will be determined through Phases I and II, a variety of (potential) strategies are described.

Objective 1: Implement a quality mass media, public information and education campaign based on sound social marketing concepts.

Objective 2: Implement education interventions directed toward schools and youth, particularly in those areas where the Maine Youth Tobacco Use Survey indicates high use prevalence of smoking concurrent with smokeless tobacco use.

Objective 3: Implement tobacco use intervention programs using health providers, particularly physicians, dentists, nurses and pharmacists.

Objective 4: To develop new, or promote existing, self-help materials for smoking cessation.

Phase IV: Evaluation

Program monitoring, quality assurance and evaluation.

Objective 1: Develop and implement project monitoring and evaluation systems.

The DBIR Project, built on a strong foundation of previous tobacco prevention and control initiatives, will have a very strong synergistic, complementary effect on implementing ASSIST in Maine.

The above cited programs constitute federally-funded projects with direct implication for the implementation of ASSIST.

State of Maine

Technical Questions

Factor 1: Management Approach

Question 7: Please provide justification for the purpose and function of the proposed Expert Advisory Committee and describe in detail how it is consistent with the Statement of Work.

Based on a review of the Statement of Work, the proposed Expert Panel Review was eliminated from the Best and Final Offer. A revised Management Plan, Section V, is provided which deletes this item and the previously proposed subcontractor.

State of Maine

Technical Questions

Factor 2: Organizational Experience

Question 1: Please document American Cancer Society's (ACS) experience in working with target population.

A detailed description of the American Cancer Society, Maine Division, Inc. was provided in the Technical Proposal, Section VIII, Voluntary Health Agency Qualifications. The response to this question provides clarification to that section (pp. 196-211) of the Technical Proposal. A revised ACS, Maine Division contribution is presented in response to this question due to proposed budget changes since the original business proposal submission. Section VIII provided information on the following target populations and channels: health care providers, vocational technical high school students, expectant parents, preschool children, adolescents and general public information activities. Further clarification is provided below.

The majority of efforts in the area of smoking prevention and intervention have been focused in youth. Over 25,000 youth are reached each year with educational programs related to smoking. This represents over 10% of our potential population. Specifically, the audience is young pregnant women, less educated/heavy smokers who attend vocational school or alternative programs, and smokeless tobacco users.

The Great American Smokeout is the primary vehicle for identifying the high risk audience. Through this upbeat, good natured event, more formal programming is implemented. The event which is promoted to every school building (over 1,000) reaches thousands of students with anti-smoking information and demonstrates ACS's ability to mobilize resources statewide.

Vocational and alternative schools are targeted to reach a high risk population of less educated youth who often work part-time or full-time in the blue collar industry, thus creating an even high risk of not only smoking but a tendency to smoke more cigarettes per day than college prep students.

The Maine Division has used the Breaking Free Program and other resources in reaching this target population. After piloting Breaking Free in six vocational technical schools and receiving positive feedback from both students and teachers, it has been integrated into over a dozen schools as part of their curriculum and used by others more informally. During 1989-90, approximately 4,500 students used the Breaking Free materials which consist of a discussion guide, computer software, video, comic book and poster. This activity has led to the involvement of state and local educators who has specific interest in further promoting the availability and use of these materials.

Young women who are pregnant are another target group which ACS has experienced success. There are two ways we appeal to expectant parents on the smoking issue. The first and most immediate, of course, is to describe the effects smoking has on the fetus. But women who quit smoking in order to protect their unborn children are not always motivated to stay off cigarettes after the baby is born. In fact, the

stresses involvec .th being a new mother can prompt ne people to resume smoking. For this reason, we provide maintenance programs specifically geared toward women who have given up cigarettes during pregnancy.

Our second avenue of appeal is to make new parents aware of the relationship between parental smoking and adolescent smoking in years to come. It is widely known and understood that children form their ideas about what it is to be an adult by watching and imitating their parents. It may also be true that even in infancy, children are aware of their parents' smoking behavior and are influenced to copy it later in life. In any event, we know that children who live with smokers are statistically more likely to become smokers themselves. Thus, by reaching expectant parents with these statistics, which predict that they put their own children at risk when they smoke, perhaps we can persuade them to eliminate cigarettes permanently form their lives.

The program utilized in reaching expectant parents is Special Delivery, which is particularly appropriate for low income pregnant smokers for two reasons, risk and access, as follows:

Risk: Poor nutrition and lack of regular health care often leave pregnant women from low income groups prone to a wide range of health problems. If these women smoke, the risks are even greater for them and their unborn children.

ACCESS: Low income pregnant women are not likely to attend stop smoking clinics.

With this in mind, Special Delivery has been implemented statewide via the Women, Infants and Children (WIC) Program. Our goal is to reach half of the 1,800 clients in Maine who smoke during 1990-1991. In addition, six of the Family Planning Clinics also utilize the program with their clients both on site and in school settings. A number of physician offices have also begun to use Special Delivery with their patients.

Students in grades 5-8 are reached with smokeless tobacco education by use of a curriculum developed by ACS and the Office of Dental Health. Through school nurses and health educators the curriculum has been implemented in over 100 classrooms. Additional support has been given through four regional trainings provided for junior high school coaches.

We have come to understand that smoking intervention must be directed at 4th, 5th and 6th graders, as well as 7th and 8th grade children. Intervention is the process of "stepping in" at the precise moment when a young person is first experimenting or thinking about experimenting with cigarettes, and offering that child concrete techniques to help deal with the social pressures which often accompany cigarette experimentation. Our intervention program provides skills-training to help adolescents acquire personal competence and resist social pressure. Role-playing, the use of peer leaders, and a discussion of the social consequences of smoking are some of the techniques which are used. Educational programs targeted at this audience reached over 5,000 students during 1990.

By addressing children at an early age, we hope to better prepare them for the peer pressures that they will face in early adolescence, which often lead to smoking experimentation. Children under the age of five are already in the position to begin forming opinions about smoking, even though they may not yet be experimenting with cigarettes.

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The program developed to address preschoolers is Starting Free: Good Air for Me. The program is designed to help young children learn polite ways to tell a smoker or other adults how smoke makes them feel and be able to leave a room when someone is smoking.

Here in Maine, Starting Free: Good Air for Me was piloted at the University of Southern Maine Day Care. For the fifty plus children attending, the program provided an opportunity for meaningful discussions and expressions of attitudes regarding cigarette smoking. Since this pilot project in 1989, the program has been offered to all day care centers and requested for use by over 25% of them. The total number of children receiving this program during 1990 was 1,928.

Other means of reaching youth have been demonstrated by ACS activity with YWCA's, YMCA's, girl/boy scouts, Key Clubs, summer camp programs and youth church groups. These activities account for over an additional 15,000 youth who are educated each year outside the school setting.

ACS's experience related to other target populations include:

Blue Collar Workers - Through the dozens of Chambers of Commerce, the manufacturing and farming industries have been targeted as priority audience to receive smoking related education. ACS activities have expanded recently to accommodate rural worksites and the traditional three-shifts associated with this population. Nearly 8,000 blue collar workers have benefited from ACS programs. Much of the success can be attributed to our close association with United Way which provides a vehicle during their campaign to this high risk group.

Ethnic Groups - both the Franco-Americans and Native Americans represent priority audiences for ACS activity. To date, each reservation has trained FreshStart facilitators who offer cessation programs on an on-going, year-round basis. These facilitators are recruited and trained via Tribal Councils and health centers, especially for the Penobscot and Passamaquoddy tribes.

Advisory board members from the Franco-American Centre at the University of Maine provide valuable input to promoting, planning and conducting educational programs which are tailored for Franco-Americans. Social clubs, such as Le Club Calumet and churches are a primary location for smoking control activities. Clubs in general represent nearly 25% of all adult activity.

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AMERICAN CANCER SOCIETY CONTRIBUTION

	Contract Year						
	1	2	3	4	5	6	7
A. Direct Labor							
1. Salaries	25,983	26,561	78,572	80,143	81,746	83,381	85,049
2. Benefits	5,456	5,578	16,593	16,925	17,264	17,609	17,961
Subtotal	31,439	32,139	95,165	97,068	99,010	100,990	103,010
B. Other Direct Costs							
1. Travel Expenses							
a. Staff	5,760	3,760	5,948	4,145	4,352	4,570	4,799
b. Volunteers	1,545	945	1,732	1,860	2,304	2,497	2,749
2. Training	2,950	1,825	4,110	3,266	3,429	3,600	3,780
3. Literature	8,642	6,903	9,179	7,466	7,765	8,076	8,399
4. Copying/Printing	5,309	4,792	6,080	5,385	5,708	6,050	6,413
5. Postage/Shipping	3,441	3,207	4,399	3,603	3,819	4,048	4,291
6. Utilities/Phone	3,917	4,230	4,568	4,933	5,328	5,754	6,214
7. Equipment							
a. Purchase	1,288						
b. Maintenance	500	540	583	630	680	734	793
Subtotal	33,352	26,202	36,599	31,288	33,385	35,329	37,438
Total	64,791	58,341	131,764	128,356	132,395	136,319	140,448

Organizationa_ xperience:

Additional Note RE: ACS-Bureau of Health Relationship

Since the submission of the original ASSIST Proposal, the proposed Maine ASSIST Project Director, Randy Schwartz, has become a members of the American Cancer Society's, Maine Division Board of Directors and a members of its public education committee.

State of Maine

Technical Questions

Factor 3: Coalition Member Experience

Question 1: Please identify specific community groups in addition to the Catholic Church for reaching the Franco-American target group. Provide a plan for involving other appropriate groups in planning and intervention delivery.

In addition to the Catholic Church, Franco-Americans can be reached through local ethnic social and recreation clubs; for example, Le Club Calumet (see page 54, Technical Proposal). Moreover, two PATCH (Planned Approach to Community Health) sites coordinated by the Division of Health Promotion and Education have a substantial Franco-American population: the St. John Valley PATCH in northern Maine and the Greater Waterville PATCH in central Maine. Both sites have identified smoking prevention and control as a high priority for intervention. Furthermore, both sites have Franco-Americans active in their steering committees and community coalitions. As noted in the Proposal, another channel for reaching Franco-Americans is the Franco-American Centre at the University of Maine. The Centre publishes a bilingual newsletter. Although the Centre is housed at the University, its advisory board is comprised of Franco-American leaders from all regions of the state (Dr. Hoover is the State Coordinator for PATCH and served for several years on the Franco-American Centre Advisory Board).

These groups will be utilized not only to delivery interventions but will be actively involved in planning as well. As indicated in the proposal, a structure has already been established via a Minority and Multicultural Technical Resource Group (TRG) to facilitate planning and implementation that is culturally appropriate for these populations. As they deem appropriate, the TRG may establish separate groups for Franco-American and Native Americans. These groups may further subdivide; for example, the Franco-American TRG may want to form additional subgroups for women or for youth or they may decide to divide into regional groups to reflect subcultural differences within the Franco-American population such as rural Acadian or the mill experience of urban Franco-Americans in central and southern Maine. However, multicultural participation in the ASSIST Coalition will not be limited to the TRG.

The Minority and Multicultural TRG may choose to work as a single entity for special purposes. For several years Maine Franco-Americans and Native Americans have collaborated to advocate for and, in some instances, provide culturally-specific programming in the health and social sectors; for example, through the Katahdin Area Health Education Center (KAHEC) and the Eastern Regional Council on Alcohol and Drug Abuse. Based on these and other efforts, a new group, the Maine Multicultural Coalition, is in the process of formalizing its structure. This group will be an important resource to Project ASSIST. Key members of this new group are also members of KAHEC, the Franco-American Centre, Central Maine Indian Association and Penobscot, Passamaquoddy and Maliseet and Micmac tribes.

Currently, KAHEC is in the process of merging with the Maine Consortium for Health Professionals Education (MCHPE). The purpose of

the new organiza_ on (still unnamed) is to improve the ality and accessibility of culturally appropriate formal and continuing health professions education and to recruit representatives of underserved cultural groups into the health professions. The new organization will be an important channel not only for the planning and implementation of culturally-appropriate interventions, but it will also provide opportunities to make an impact on health service and education providers who work with minority and ethnic groups. (Dr. Hoover is a member of the KAHEC Board and a participant in the Merger Committee.)

State of Maine

Technical Questions

Factor 3: Coalition Member Experience

Question 2: Provide a plan for extending membership in the coalition in order to reach various target populations identified in the site analysis. Especially document ability to reach high risk groups such as workers, youth, women, minorities, and other groups unique to this state.

The coalition is structured to accommodate various levels of organizational or individual involvement including participation on the advisory board, on primary and secondary subcommittees and/or in technical resource groups. As discussed in the technical proposal "...the subcommittee structure will involve a primary subcommittee and a secondary subcommittee network. The primary subcommittee will include all those organizations and individuals with a strong interest and/or active working relation to a specific channel. It may include members who are new to tobacco prevention and control but, important for the goals of ASSIST or interested in getting more involved. The primary subcommittee will have major responsibility for the smoking prevention and control workplan for its specific channel which will necessitate a more intensive involvement.

The secondary subcommittee will include those organizations with an interest in ASSIST, individuals or groups from specific target groups and those with less direct or intensive interest. They will receive information about ASSIST through newsletters and other communications. The involvement of secondary subcommittee members will hopefully increase over time as they gain a greater understanding of the need for a comprehensive public health approach to tobacco prevention and control.

The structure of the Maine ASSIST Coalition is presented below. Numerous organizations have committed to be active participants in the Coalition. Organizations will naturally have differing levels of involvement which the structure allows for. A diagram (p. 146) is followed by a detailed explanation of the structural components.

1. The membership of the Maine ASSIST Coalition is designed to address the target populations through specified intervention channels and settings. Although numerous organizations and individuals have committed to participation in the ASSIST Project, continuous attention will be paid to membership recruitment to cover gaps in the existing structure and to membership retention to make certain that participating groups continue to participate, to maximize likelihood that all relevant parties are involved, and to continuously revitalize efforts.

The Maine ASSIST Coalition is designed as a broad, diverse group consisting of many members in order to impact the tobacco problem in every aspect of community and social life. However, in order to accomplish the necessary tasks in planning and intervention the Coalition involves the following subcommittees.

The subcommittee structure is designed around the intervention channels. However, each subcommittee will design workplans to explicitly reach target groups).

Each subcor .ttee chairperson will serve on the SIST central Advisory Committee thus facilitating communication between subcommittees. Each subcommittee will also have a liaison to a secondary subcommittee.

Each subcommittee will have an explicit charge to address smokers in general as well as the specific high risk target populations:

- Youth
- Ethnic Minorities
- Women
- Blue-collar workers.
- Less educated individuals
- Unemployed persons
- Heavy smokers
- Smokeless Tobacco Users

In addition, each subcommittee will have an explicit charge to integrate interventions related to the community environment into their work. The term "community environments" is defined as:

> "The general physical and social milieu in identified areas within the intervention site. The community environment as a channel consists of the multiple outlets in a community that reach all citizens regardless of employment, scholastic, health, social or smoking status. The presence and salience of messages promoting smoking or quitting, the availability (or lack thereof) of cigarettes and smokeless tobacco and the social norms for smoking in public places all contribute to a community environment that may or may not support smoking" (NCI 1989).

The ASSIST planning group determined that this channel, in effect, spanned all intervention channel settings. It was thus decided not to make this a separate subcommittee but to integrate the channel goals into the work of all the subcommittees.

The goals include:

- reducing the number of pro-smoking cues and messages in the community environment, including smoking in public places, cigarette advertising, tobacco-sponsored sporting and cultural events, and the widespread availability and affordability of cigarettes.

- increasing the number of cues and messages supporting non-smoking in the community environment, including the strategic use of planned media campaigns to promote non-smoking, quick and effective response to tobacco- and smoking-related news events to present the non-smoking point of view in the media, and the highly visible promotion of available program services in public places throughout the community."

Primary subcommittees are health care, educational systems, worksite, and community network. Each of these subcommittees will have additional subcommittees (secondary) which can be focused on issues such as policy or on target groups such as women or heavy smokers or by region or by some other task identified by the primary subcommittee. The worksite subcommittee would logically focus on, but not be limited to, blue collar workers. As pointed out in the proposal "Members of this subcommittee have been selected due to their extensive experience

in working with educational systems, knowledge of prevention of smoking in youth, or ability to influence the educational systems to promote policy changes. Selected members include:

- Jane Ann McNeish, Prevention Coordinator, American Lung Association of Maine
- Department of Educational and Cultural Services, Division of Alcohol and Drug Education Services
- Maine School Boards Association
- Maine School Health Education Coalition
- Maine Elementary Principals Association

Pat Jones, Public Health Educator, will staff this subcommittee. Ms. Jones has experience in linking community health education and school health education. She served as staff of the Cessation Resources subcommittee of the Governor's Commission on Smoking OR Health."

How to reach minorities was discussed in the response to Factor 3, Question 1, but to reiterate, the Minorities and Multicultural Technical Resource Group will be established. This group will be a resource to any and all committees or subcommittees in the coalition. This does not mean, however, that minority participation will be limited to the TRG. Some may prefer to participate in the subcommittees; others may prefer to participate in the TRG only for specific purposes or tasks. Potential members of the TRG, for example, have already indicated to us that they would prefer that level of involvement. The subcommittee and TRG structure will enable us to have a much broader level of participation of multicultural and minority groups.

The educational systems subcommittee will have youth as its primary focus. members of this subcommittee include the Maine Department of Education, Division of Alcohol and Drug Education Services (DADES), Maine School Boards Association, Maine School Health Education Coalition and Maine Elementary Principals Association. With the exception of DADES, these groups affect the system and will be important in policy development. To reach each youth directly will require the participation of groups such as Big Brothers/Sister, YMCA/YWCA's, the Cooperative Extension (4-H, Youth at Risk - see below). All of these groups have expressed their commitment to Project ASSIST (see Appendix). We will draw upon their membership to participate in both the educational systems and community networks subcommittees. It will be important to have youth as well as those who work with youth participate directly in the subcommittees.

As indicated in the proposal (p. 54) there are numerous community networks specific to each target group:

- Youth - Channels for this group include Boys/Girls Clubs, YMCA, YWCA, 4H, churches, vocational schools, schools (elementary, secondary), government job training programs, Little League and other youth sports leagues, Boy/Girl Scouts, Big Brother/Sister, Family Planning, Coalition for Maine's Children, Office of Truancy, Dropout and Alternative Education.

- Ethnic minorities - The Franco-American Center at the University of Maine publishes a bilingual newspaper and has an advisory board comprised of Franco-American leaders from throughout the state. There are also ethnic social clubs such as Le Club Calumet. Native Americans can be reached via Tribal Councils and health centers especially for the Penobscot and Passamaquoddy tribes.

Catholic or ganizations such as Knights of Columl and the Catholic Church are channels for Franco- Americans and Native Americans. Additional groups include National Association for the Advancement of Colored Persons and Black Education and Cultural History, Inc.

- Women - Channels for this group include: WIC (Women, Infants, and Children), ASPIRE (Department of Human Services/Department of Labor sponsored work transition program), Aid to Families with Dependent Children, displaced homemakers, job-training programs, Family Planning, churches, Weight Watchers, Lionesses, and the Maine Women's Lobby.

- Blue Collar Workers - Channels for this group include: the Maine State Employees Association, the Maine Labor Group on Health, Maine Municipal Association, Bureau of Employment and Training Program, Displaced Homemakers, Maine Snowmobile Association, and other sporting recreational groups. A number of groups representing specific occupations and industries exist such as the Maine Forest Products Council, and the Maine Paperworkers Association.

- Unemployed - Job training programs, the Department of Education and the Maine Job Service include services to reach unemployed workers.

- Low Income - There are numerous advocacy groups, action councils and neighborhood associations representing low income citizens. These include: We Who Care, Maine AFDC Advisory Council, Maine Association of Interdependent Neighborhoods (M.A.I.N.) among others."

Moreover, a membership committee will be established to ensure a continuous recruitment of individuals and groups relevant to the Coalition's plan of work. This was indicated in the Technical Proposal in the following places.

State of Maine

Technical Questions

Factor 3: Coalition Member Experience

Question 3: The proposal notes that physicians deliver most health care in State but they are not strongly represented on coalition, subcommittees, or the Executive Committee. Please discuss the planned involvement of physicians in the project.

Physicians will, in fact, be integrally involved in the Maine Project ASSIST. The Maine Bureau of Health has excellent relationships with practicing physicians in the implementation of many public health intervention programs. A review of many of the ASSIST Coalition members indicates numerous linkages to physician networks and organizations. The Maine Coalition on Smoking OR Health involves over thirty health organizations including physician specialty groups. Numerous physician specialty groups have tobacco prevention and control subcommittees. This will be reviewed below.

There is extensive physician involvement in many of the Bureau's programs. For example, the Cancer Prevention and Control Advisory Committee (which will be integrally involved in Maine Project ASSIST) has several physician members including Dr. Donald Magioncalda, Committee Chair; the Diabetes Control Project Advisory Committee has many physician members from a variety of specialties; the TB Advisory Committee and AIDS Advisory Committee each have numerous physician members; the Maine Cardiovascular Health Council which advises the Division's Cardiovascular Disease Prevention Program has had extensive physician involvement for year. Thus, as the question states, whereas much care is provided by physicians in Maine, as a result, the public health and medical communities have developed long-term, extensive partnerships in almost every public health project undertaken in the State.

The Division of Health Promotion and Education has developed partnerships with and done training for physicians in the area of tobacco prevention and control. This includes the following:

(1) Training for the Maine Thoracic Society on the NHLBI Clinical Opportunities for the Busy Physician Program.

(2) Training for the medical staff of Eastern Maine Medical Center on the Clinical Opportunities Program.

(3) Provision of the NCI Train the Trainer Program on "How to Help Your Patients Stop Smoking, A National Cancer Institute Manual for Physicians" to over thirty physicians.

(4) Ongoing relationship with the New England College of Osteopathic Medicine regarding integration of tobacco prevention and control interventions into undergraduate medical curriculum, medical practice and other physician initiatives.

Thus, the Bureau of Health has a track record on working with physicians on tobacco control.

The Execut Committee as proposed includes t physicians. It will include Lani Graham, MD, MPH, the Director of the Maine Bureau of Health. Dr. Graham is a member of the Maine Medical Association and is active on its Legislative Committee. The Executive Committee also includes Donald Magioncalda, MD. This was indicated on Executive Committee membership (pp. 159-160 of the Technical Proposal).

The Chairperson of the Maine Coalition on Smoking OR Health, Laurie Radovsky, M.D. is a practicing family physician in Strong, Maine located near the Franklin County intervention site. As previously stated, the Maine Coalition on Smoking OR Health includes many medical specialty groups who will be involved in the Project.

Section VI of the Technical Proposal presents the Maine ASSIST Coalition. A review of the coalition members and subcommittee structure indicates numerous organizations through which physicians will be involved.

The Health Care System Subcommittee (pp. 148-149) includes:

- The Maine Ambulatory Care Coalition - representing rural and community health centers. Physicians will be recruited from this organization.
- Maine Consortium for Health Professions Education - provides education and training for health professionals; numerous physicians involved.
- American Lung Association of Maine - their Technical Committee on Smoking OR Health is chaired by a family physician, Roy Miller, M.D. The Committee and Dr. Miller will participate.
- University of New England College of Osteopathic Medicine - Maine's only medical school; has a history of collaboration with the Bureau of Health.

The Worksite Subcommittee includes:

- The occupational health physician from Maine's largest employer, Bath Iron Works - Dr. Diane Parotte.
- Maine Labor Group on Health.
- American Heart Association of Maine - numerous physician volunteers with AHA will be involved.

Other Coalition members with physicians who will be involved include:

- Maine Cardiovascular Health Council.

A complete inventory of physician organizations and intervention channels will be completed. The Membership Committee, as described in the Technical Proposal, will develop membership strategies to involve physicians.

The Appendix to the proposal included letters of support from the American College of Physicians, Maine Chapter, Dr. Paul Shapero, Chair of the Allergy and Immunology Association and other relevant physician organizations.

State of Maine

Technical Questions

Factor 3: Coalition Member Experience

Question 4: Please describe how other State programs will participate in ASSIST interventions through participation in Phase I planning.

There is currently a well-established, integrated and cooperative relationship on tobacco prevention and control issues between State programs through several mechanisms. These have been described in the Technical Proposal and will be reviewed below. The various State programs engaged in tobacco prevention and control will participate in relevant workgroups, subcommittees, Advisory Committee and other aspects of the ASSIST structure. In addition, State programs with the ability to reach the target populations will be inventoried and enlisted for participation in Phase I and subsequently Phase II activities. This will be described below.

The Division of Health Promotion and Education (DHPE) convenes the Interdepartmental Tobacco Coordinating Committee which includes all state agencies with an interest in tobacco prevention and control (described on page 96 of the original Technical Proposal). "To coordinate tobacco prevention and control activities, and maintain a flow of communication, an Interdepartmental Tobacco Coordinating Committee was convened by the DHPE. It is chaired by the Director of the DHPE and meets quarterly."

State agencies involved in prevention and control and participating in the Interdepartmental Committee include:

- The Bureau of Health
  - Division of Health Promotion and Education
  - Office of Dental Health
  - Division of Maternal and Child Health (WIC and Prenatal programs)
  - Division of Health Engineering (Indoor Air Quality - ETS)
- Bureau of State Employee Health (Department of Administration) - responsible for health promotion including smoking cessation for state employees
- Office of Substance Abuse
- Department of Education
  - Division of Curriculum
  - Division of Alcohol and Drug Education Services

The DHPE maintains a direct collaborative relationship with many of the above programs as well as with other programs. A collaborative, networking, information-sharing relationship, at the least, is maintained with all of the programs. In addition to the above, the Division of Health Promotion and Education works with the Division of Public Health Nursing to integrate tobacco cessation intervention skills into the practice and protocols of Maine's public health nurses. A direct collaborative relationship is maintained with the Office of Dental Health (smokeless tobacco) and the Division of Maternal and Child Health (DMCH) (prenatal smoking cessation). The DHPE and DMCH have been collaborating on implementing a prenatal

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smoking cessatio. :ogram in a variety of settings incl hg WIC agencies, prenatal clinics, rural health centers, family planning agencies, etc. The Bureau of Health has been receiving technical assistance from CDC's Division of reproductive Health in developing this initiative.

The Bureau of Health's Cancer Prevention and Control Team includes representatives from each Division in the Bureau. It serves as a planning and coordinating body for cancer intervention activities within the Bureau. The team is integrally involved in the implementation of the Data-based Intervention Research (DBIR) for Cancer Prevention and Control in Public Health Agencies Project and will be involved in the implementation of ASSIST. The ASSIST Project will be a regular agenda item at each meeting. In addition, Bureau cancer team members will be involved in all aspects of implementing the ASSIST Project in Maine.

The Cancer Prevention and Control Advisory Committee was established in statute by the Maine State Legislature in 1987. It was described in The Technical Proposal (pp. 189-191). The mission of the Cancer Prevention and Control Advisory Committee is "to advise the Commissioner, Department of Human Services, in the development of a State Cancer Policy and on a coordinated statewide approach to cancer prevention and control." The following are committee responsibilities:

- Priority-setting consultation for both cancer prevention and control.
- Technical assistance/advice on Bureau programmatic activities.
- Coordination of resources in cancer prevention and control.
- Management consultation to the Cancer Registry.
- Advocacy for adequate resources for cancer prevention and control;
- Coordination of an annual cancer prevention and control conference to coincide with the release of the Tumor Registry report;
- Communication among members and others on significant cancer prevention and control initiatives within Maine and the Nation;
- Consultation on cancer prevention and control issues.

The Management Plan presented in the Technical Proposal indicated that Maine Project ASSIST will be a regular agenda item at every meeting of the Cancer Prevention and Control Advisory Committee.

There is very strong support for Maine Project ASSIST by the State Health Officer, Dr. Lani Graham. Dr. Graham will serve on the Executive Committee. She has been integrally involved in tobacco prevention and control policy and legislative interventions in Maine. Dr. Graham will assure the participation of all relevant Bureau programs in Maine Project ASSIST. In addition, through Dr. Graham's interaction with other Bureau Directors and state agencies, participation in ASSIST will be promoted to a variety of state agencies. The Project Director and Project Manager will also actively promote participation in ASSIST Phase I and Phase II activities to all State agencies.

In addition to the above programs in which there is a direct, primary tobacco control relationship, there are numerous State agencies that provide services to target groups of interest to the implementation of the ASSIST Project.

The Maine ASSIST Coalition will include representatives not only from those state agencies that provide services to the target groups of interest but from members of the target groups themselves. The Technical Proposal indicated several of these State agencies including:

- Department of Education, Office of Truancy, Dropout and Alternative Education
- Department of Labor, Bureau of Employment Security
- Office of Substance Abuse
- Department of Education, Division of Alcohol and Drug Education Services
- Department of Education, Division of Curriculum
- Department of Administration, Bureau of State Employee Health
- Department of Human Services, Bureau of Elder and Adult Services

An inventory of all state agencies relative to target populations, intervention channels and settings will be conducted. The Project Manager will conduct orientation meetings for all State agencies which are judged as relevant for participation in ASSIST.

State of Maine

Technical Questions

Factor 3: Coalition Member Experience

Question 5: In order to ensure the involvement necessary to achieve ASSIST Objectives, how will Executive Committee and Coalition membership be determined? In order to accommodate to changing demands, how will the membership of these two bodies expand, adapt and renew their membership?

Issues of Coalition and Executive Committee membership and structure are addressed in several places in the original Technical Proposal. These will be reviewed and clarified below and in addition, further clarifying information provided.

First of all, as a broad reference to the above question, the Technical Proposal Introduction indicated (page 3) "Maine's public health and health care community has a rich history of coalition-building for action for health." (and named numerous health coalitions that have been active in Maine).

An extensive and detailed Maine ASSIST Coalition was proposed in Section VI of the Technical Proposal and a detailed Management Plan was proposed in Section V. Both of these sections have information that is extremely relevant to this question.

The introduction to Section VI, Maine ASSIST Coalition stated, (page 143) "The Coalition is structured to maximize the use of existing resources, reach the intervention channels and target populations most efficiently and effectively, and enlist new groups and organizations into the state's tobacco prevention and control initiative."

An examination of the structure presented on page 146 indicates a wide variety of potential opportunities for participation. At this time numerous organizations and individuals have committed to be active participants in the Coalition. (page 145) Organizations will naturally have differing levels of involvement which the structure allows for.

Regarding membership, the Technical Proposal further indicated the membership of the Maine ASSIST Coalition is designed to address the target populations through specified intervention channels and settings. Although numerous organizations and individuals have committed to participation in the ASSIST Project, continuous attention will be paid to membership recruitment to cover gaps in the existing structure and to membership retention to make certain that participating groups continue to participate, to maximize likelihood that all relevant parties are involved, and to continuously revitalize efforts.

The Technical Proposal indicated that a standing Membership Committee would be established (pp. 157-158). The Membership Committee will play an integral role in the recruitment of new members and the retention of existing Coalition members. They will ensure that all relevant organizations are involved, that participating groups continue to be active, and continuously revitalize efforts. The

The Technic Proposal proposed, "Development c Project ASSIST orientation manual" (page 119). This will help institutionalize Coalition orientation which will be applied to the membership recruitment issue. ASSIST Coalition communication activities will also contribute to membership recruitment (page 122, 123-124). Communication strategies were detailed on page 123 such as:

1. Production and distribution of Maine Project ASSIST newsletter.

2. Production and distribution of camera ready articles for newsletters of member organizations.

3. Production and distribution of a directory of all Maine ASSIST Coalition member organizations including organization name, contact person, phone number and fax number.

4. Use of existing electronic bulletin boards -

   - Department of Education bulletin board connecting all school systems
   - Vocational College system bulletin board

5. Utilization of the University's interactive television, (ITV) system (through the subcontract) which links sites throughout the state.

6. Subscription to SCARCNET, the Smoking Control Advocacy Resource Center electronic bulletin board system (DHPE currently subscribes). Action alert items and other SCARCNET postings will be downloaded and distributed as necessary. Information on subscribing to SCARCNET will be provided to all Coalition members as well.

Training activities will also help to recruit new members and maintain the commitment of existing members (detailed on pp. 128-132, Technical Proposal).

The Project Management Plan (page 128) will include items related to membership recruitment, renewal, and adaptability. The Annual Coalition Action Plan (page 140) will include "relevant portions of the Phase II plan, set annual goals and objectives, and describe Coalition wide events and other activities." This plan will be publicized and used as a membership recruitment tool.

Executive Committee:

The RFP for ASSIST provided statements on Executive Committee structure, roles and responsibilities and membership: (From RFP page 38)

> "An executive committee shall be formed to coordinate and manage the project within each site. This Executive Committee will have equal representation from the American Cancer Society (or other QVHA) and the health department and representation from the coalition that does not exceed 50% of either the ACS (or QVHA) or health department individual representation. A suggested model would consist of three employees of the health department (e.g., the Project Director, the Project Manager, and another staff member), three ACS or (QVHA) representatives and a representative of the Coalition. The total membership of the Executive Committee shall not exceed 12 individuals."

and on page indicated roles and responsibilities:

> "Executive Committee: set planning and budget parameters, determine program direction; set program goals; approve overall coalition plans as recommended by the coalition; supervise implementation of the coalition plans."

The Maine ASSIST Executive Committee structure was detailed on page 159-160 of the Technical Proposal and adheres to the RFP.

The Technical Proposal stated: "The ASSIST Executive Committee will be formed to coordinate and manage the project. The Executive Committee will be the major policy body for Project management. It will set planning and budget parameters, determine program direction, set program goals, approve overall coalition plans as recommended by the coalition, and supervise implementation of the coalition plans.

The Executive Committee will include from the Maine Bureau of Health:

- Randy Schwartz, MSPH, Director, Division of Health Promotion and Education, ASSIST Project Director (Mr. Schwartz's experience is described in detail in the personnel section.)
- Sandra Hoover, PhD, MPH, Project Manager (Dr. Hoover's experience is described in detail in the personnel section.)
- Lani Graham, MD, MPH, Director, Maine Bureau of Health (State Health Officer) - Dr. Graham is the State Health Officer for Maine. She has experience as a local health officer and was previously Director of the Division of Disease Control in the Maine Bureau of Health. Dr. Graham is the Principal Investigator of the Maine Breast Cancer Control Project. She has experience in communicable and chronic disease public health interventions. She is trained in family practice.
- Beverly Entwhistle, RDH, MPH, Director, Office of Dental Health - Beverly Entwhistle is currently Director, Department of Human Services' Office of Dental Health. Previously she was Associate Professor at University of Colorado School of Dentistry, Department of Applied Dentistry, teaching public health, geriatrics and special patient care, as well as directing the Dental Extramural Program. Ms. Entwhistle is active in AAPHD and ASTDD, and serves as the Program chair for the Dental Health Section of APHA for 1991-92.

From the American Cancer Society, Maine Division, Inc:

- Alan Anthony, Executive Vice President - During his twenty years with the American Cancer Society, he has been involved with a variety of smoking/lung education programs. He was instrumental in the formation of the HOT (Health or Tobacco) Coalition. Alan's particular expertise is in legislative issues.
- Vicki Purgavie, Public Education Director - Vicki has been a staff member with the American Cancer Society for over six years. Her primary responsibility is with Public Education. She currently serves as secretary for the Maine School Health Education Coalition (MeSHEC) and holds memberships with the Maine Public Health Association (MPHA) and the Maine Association of Health, Physical Education, Recreation and Dance (MAHPERD).

- Donald Mag caldа, MD, ACS President - Dr. Ma ncalda is an oncology specialist at Kennebec Valley Medical Center in Augusta. He chairs the Maine Cancer Prevention and Control Advisory Committee and is a member of the Governor's Commission on Smoking OR Health.

- Joanne Bean, RN, MBA, ACS Public Education Committee Chairperson - Joanne is the Health Promotion Coordinator at Kennebec Valley Medical Center. She holds her B.S.N. and M.B.A. In 1989, Joanne received the Jaycees Outstanding Young Mainers Award. Currently, she is President of Kennebec Valley Hospice and the Maine State Patient Education Forum, as well as a member of the legislative committee for the Maine Public Health Association (M.P.H.A.).

Additional members:

- Edward Miller, MSEd, Executive Director, American Lung Association of Maine

- John McNeill, Executive Vice President, American Heart Association, Maine Affiliate.

The Tri-Agency Coalition in Maine along with the Bureau of Health, has formed the nucleus for tobacco prevention and control initiatives. Inclusion of Mr. Miller and Mr. McNeill on the Executive Committee demonstrates the commitment to making the ASSIST Project a success in Maine and to the understanding of the magnitude of the problem and the clear need for an integrated, cooperative approach.

Functional aspects of the Executive Committee have been described in greater detail in Section V."

The By-laws will include items specific to the Executive Committee membership, structure and related items. As specified on page 160, it is also especially significant to have both the Executive Director of the American Lung Association of Maine and the Executive Vice President of the American Heart Association - Maine Affiliate on the Executive Committee in addition to the ACS and Bureau of Health representatives. This illustrates the commitment to making ASSIST work in Maine.

In addition to the above activities, Project staff outreach activities will include membership recruitment. An informational sheet on ASSIST, ASSIST rationale, roles and responsibilities of members and other items will be utilized at all meetings. Work of Project subcommittees and other units will contribute to the development of membership. In addition, the ASSIST Coalition structure allows for intensive participation or a more secondary role. This will be helpful in recruiting new members so that involvement may be progressively more intensive but allows for a less intensive involvement - either in the beginning or one may shift back and forth between primary and secondary involvement as issues permit and other demands may neccessitate. The Coalition member organizations themselves will also be enlisted into an ongoing membership recruitment initiative.

The by-laws and subsequent procedures will address all issues raised regarding membership. As indicated above, numerous items regarding this issue were presented in the original Technical Proposal.